SKIN SPECIALISTS
OF THE CAPITAL REGION
SKINSPECIALISTSCR.COM

MOHS PATIENT REFERRAL FORM

Please fill out the information below when referring patients to our office and fax to 518-362-1348

Date of Referral:

Referring Physician name & Fax number:

Patient Name:

DOB:

Address:

Phone #'s H - W- Other -

Location of Lesion:

App. Size of Lesion: smaller than pencil easer/larger than dime/In between

Has lesion been biopsied? **(Please Fax Report)**: Yes/No

Is there a Photo or Map of the area? **(Please send)**: Yes/No

Diagnosis: BCC/ SCC/ Other: _____

Has PT even had melanoma in the Past?: Yes/ No - If so When: _____ Treated by Whom _____

Circle one: in-situ/_____mm

Patient Contact: We should contact patient/ Patient will contact us

History of Dementia/Alzheimers Yes / No **Health Care Proxy: Yes / No**

Nursing Home Patient? Yes / No

For nursing home patient please list phone number and contact person at nursing home.
Is the patient able to comprehend & sign consent forms (alert & oriented)? Yes/ No
****If, No please fax a copy of the patients Health Care Proxy Forms. (518) 708-8749**

*****Please fax us a copy of patient's demographic and insurance card(s).**

FOR INTRA OFFICE USE

DOS: **Update: 06/22**